The dark side of urology: exposing decades of unethical and ongoing experimental penile neurotomy practices

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Penile neurotomy (PN), introduced as an experimental treatment for lifelong premature ejaculation (PE), involves severing or cauterizing deep ventral penile nerve branches vital for sexual sensation and reflexes, particularly in the frenular delta (Fig. 1). During the 1990s, this procedure gained traction through the practices of a small group of South American urologists and vascular surgeons, primarily–but not exclusively–Brazilian, who integrated it into circumcision surgeries.[1,2] Despite an alarming lack of robust scientific evidence and significant risks, including permanent loss of erogenous sensation and erectile dysfunction,[3,4] PN spread internationally, particularly within private urology centers where ethical oversight was often insufficient.[i]

This presentation will uncover the hidden history of PN, tracing its origins in animal experimentation[8–11] to a relatively widespread, though ethically dubious,[4] surgical intervention in humans. Early reports[12–16] from the *International Journal of Impotence Research* (IJIR), authored by neurotomists themselves, document the dissemination of this practice across multiple countries but lacked rigorous ethical/scientific scrutiny. According to one of the first experimenters with human PN,[1] the International Society for Impotence Research (ISIR), through its congresses, was instrumental in facilitating the international dissemination of PN within urology during the 1990s.[ii]

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[i] PN is also referred to in Anglophone literature by various synonymous terms, including penile selective neurotomy, dorsal neurotomy, selective dorsal neurotomy, penile neurectomy, penile selective neurectomy, dorsal neurectomy, dorsal nerve neurectomy, partial penile neurectomy, premature ejaculation surgery, selective penile denervation, partial penile denervation, selective dorsal nerve resection, penile nerve resection, microsurgical denervation of the penis, neurotripsy, and others. While the original PN technique used by Brazilian surgeons involved circumcision with total frenulectomy, along with sectioning or cauterization of the perineal nerves (located on the ventral penile aspect) and the ventrolateral dorsal nerve branches supplying the frenular region, the dorsal nerves on the dorsal penile aspect are today frequently included in PN practices. Prepuce-sparing PN techniques have also been introduced, employing penoscrotal access to target proximal ventral perineal nerves at the penile base. Moreover, PN combined with hyaluronic acid gel injections into the glans has also been used to further decrease penile sensory capacity, increasing the risk of permanent penile numbness.[5] More assaultive practices include ventral PN with additional "frenular delta excision," bilateral bulbospongiosus muscle transection ("Alaa Aglan operation"), penile degloving with proximal repositioning of the severed nerves "to avoid reunion or recurrence," and covering the proximally relocated nerve ends with an "inverted skin graft or silicone cap" to prevent reconnection.[6] Some surgeons have also routinely performed PN during phalloplasty, penile prosthesis implantation,[6] penile venous leak surgery,[7] and the Nesbit procedure,[7] further contributing to the historical and contemporary landscape of experimental, unregulated, and high-risk urological practices.

[ii] In his book, Fischer Santos[1] wrote (pp. 170-172): "At the International Society for Impotence Research Congress held in Singapore in 1994, a multitude of studies from various parts of the world were presented with promising results. The vast majority of the physicians who presented these works had learned the technique during training with Dr. Alfredo Romero. From this significant milestone, most leading medical services around the globe incorporated neurotomy into their therapeutic arsenal for addressing certain cases of premature ejaculation…At the International Society for Impotence Research Congress, held in San Francisco, USA, in 1996, our study, "Protocol for Indication of Neurotomy," competed for the Herbert Newman Prize for Clinical Research…At the Congress of the International Society for Impotence Research in Perth, Australia, in 2000…the organizer of the Congress program section on Premature Ejaculation, requested that I present our experience with Neurotomy in a plenary session as a keynote lecture. I prepared and sent…material to be presented on Neurotomy. After reviewing the material, he immediately requested confirmation of the presentation...Surely, [the] presentation was the star highlight of the Congress and the main driver for the worldwide dissemination of this technique. Neurotomy was finally established and definitively incorporated into the art and science of medicine." (Translated from Portuguese by us)

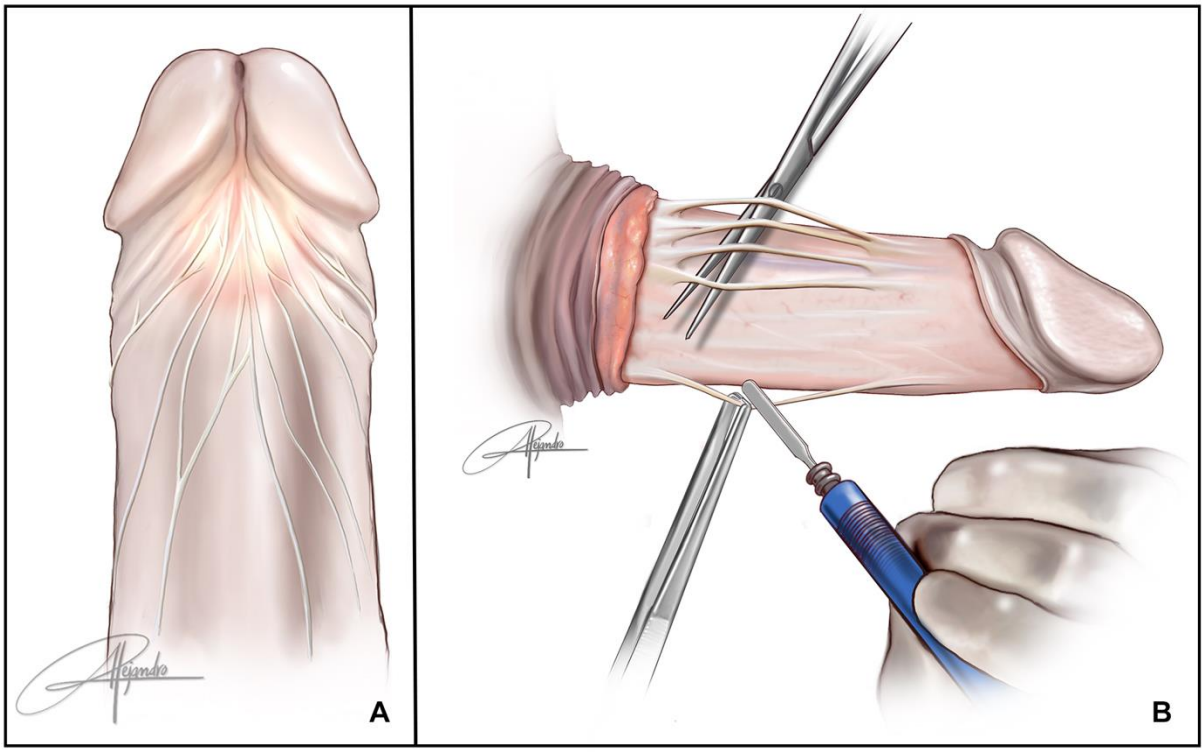

Fig 1. Human penile ventral innervation and penile neurotomy (PN). A. Ventral view of the penis showing the frenular delta, characterized by a typical V-shaped or inverted Y-shaped configuration formed by the retraction of the ventral prepuce and frenulum. This region is widely regarded by sexually functional men as the primary contributor to penile erogenous sensation.[17–20] A dense convergence of sensory nerves is depicted, many of which are directly targeted during PN. **B.** Schematic sagittal illustration of PN. The penile skin is degloved, revealing a cauterization procedure on a penile ventral branch of the perineal nerve. Four dorsal penile nerves are exposed and elevated by an underlying surgical scissor. The ventral nerve being cauterized directly innervates the frenular region, while the dorsal nerves give rise to ventral branches (shown in **A**) that also contribute to the innervation of this area. Both sets of nerves are commonly targeted during PN procedures.

We outline four phases in the historical trajectory of PN:

1) Pre-1980s (probing the penile sensory margin of safety): Animal experimentation by researchers unconnected to later human PN trials, involving species such as rats, monkeys, bulls, cats, and others.[1,8–11,iii] This animal research, carried out by basic scientists with no known connection to the South American surgeons who later introduced PN in humans, was purely aimed at understanding the regulation of mammalian sexual behavior, with no mention of PE and no intent to apply PN clinically. Nevertheless, the first Brazilian human penile neurotomists[1,2] frequently cited this work, particularly Herbert's macaque experiments,[8] misrepresenting it as a scientific foundation or justification for their human experiments, despite its originally nonclinical focus, the lack of scientific and ethical validation for human experimentation, and even ethical objections to some of the animal studies themselves.[22]

From a classical physiological standpoint,[23] the animal studies can be seen as probing the *margin of safety* in penile sensory control of erection and ejaculation, testing the threshold at which nerve ablation disrupts sexual function. These studies reported a

[iii] A rare and isolated report[21] from the late 19th century proposing PN as a means to prevent masturbation appears entirely unrelated to the four historical phases we outline, seemingly representing an isolated case. However, determining whether PN for this purpose during the Victorian anti-masturbation hysteria was an isolated occurrence or part of a broader practice requires further historiographic research.

wide margin of safety, often ablating over 90% of penile dorsal nerves while preserving basic sexual function, findings that emboldened early South American neurotomists in their human penile nerve-ablative experiments. A mindset took hold among certain urologists, one that rationalized and normalized invasive, irreversible, and high-risk experimentation on young adult patients' penises, ultimately leading some to cross legal and ethical boundaries, as detailed ahead. Viewed through this lens, the entire history of human PN uncovered here appears to be a late 20th-century (and continuing into the 21st-century) episode of unethical human experimentation on the margin of safety for penile sensory control over erectile and ejaculatory function.

2) 1980s–1994 (from Brazil to the world): Initial unregulated human experimentation by South American surgeons, beginning at an unclear point in the 1980s,[24] with PN often performed under dubious circumstances,[25,26] leading to the 1997 resolution by the Brazilian Conselho Federal de Medicina (CFM),[27] which classified PN as an experimental practice subject to strict oversight and ethical review. The resolution explicitly cited concerns regarding lack of consent in PN practices.

The unethical origins of human PN in Brazil can be traced through the Brazilian weekly news magazine *Manchete*,[28–35] which published articles from 1991 to 1998 promoting PN with sensationalist quackery, branding it as a groundbreaking, revolutionary, and miraculous cure for PE. These articles credited and featured some of the same authors referenced in the early IJIR literature as the developers of PN. Sensationalist headlines and subheads included: "*Premature ejaculation: the cure through neurotripsy*", "*Premature ejaculation: the curative surgery*", "*Neurotripsy: the stages of the revolutionary surgery*", "*Intimacy plastic surgery: the revolutionary procedures for beauty and total pleasure*", "*The end of premature ejaculation*", "*Selective penile neurotomy: a revolutionary surgery*", "*The end of men's nightmares*", "*The surgery that corrects hypersensitivity*", "*Premature ejaculation: the cure on the operating table*", "*Discover the fantastic made-in-Brazil techniques for these problems*", "*Neurotripsy: a world premiere Made in Brazil*" (translated from Portuguese by us). From the confines of Brazilian urology centers, a dangerous surgical practice emerged, irresponsibly marketed as a revolutionary innovation, performed without oversight, and unleashed globally before ever being subjected to proper scientific and ethical scrutiny. Publicly available court records[26] indicate that the advertisements misled patients by guaranteeing a permanent cure for PE. As a result, patients underwent PN, often as part of combined surgical packages that included penile prosthesis implantation, penile lengthening and girth enhancement procedures, and circumcision, interventions that led to severe physical and psychological sequelae. The case records document informed consent violations and ultimately culminated in disciplinary proceedings and judicial decisions that upheld ethical charges against the Brazilian neurotomists.[26]

One of the early Brazilian penile neurotomists reported performing over 1,000 PN procedures between the late 1980s and March 1992,[2] an alarmingly high number for a single surgeon within such a short time frame, especially for a high-risk, nerve-ablative procedure lacking any scientific evidence. By 1994, this neurotomist reported performing 1,320 PN surgeries, the majority on young adult patients, with a mean age of 26 years.[36] The ethical and medicolegal circumstances surrounding these PNs remain unclear. In publicly available court records from a lawsuit in which this neurotomist was sued for a PN performed in 2010 and found liable, he claimed to have

performed over 10,000 procedures,[37] though it remains unclear whether this figure referred specifically to PNs or to surgical procedures more broadly.

3) 1994–2001 (spreading without oversight): Internationalization phase, beginning with the 1994 6th World Meeting on Impotence in Singapore,[16] during which an anatomical theory linking lifelong PE to dorsal nerve "hyperplasia" was first postulated,[38] and culminating in the 2001 international multicenter report by Dias Bautista et al.[13] Participating countries in this multicenter study were Brazil, Ecuador, Venezuela, Chile, South Korea, Spain, and Italy. These neurotomists reported performing PN procedures on over 4,000 patients, a highly disturbing figure with many cases occurring in Brazil, without any record of IRB approval. A significant but unknown number of these procedures were likely performed after the 1997 CFM resolution, raising unaddressed medicolegal concerns about the ethical conditions under which these surgeries were conducted and whether they adhered to the strict oversight and informed consent requirements mandated by CFM. The premature international dissemination of PN had begun, driven by unrestrained investigative activities by PN enthusiasts and therapeutic exuberance on thousands of men, undertaken under ethical circumstances that remain largely undocumented and unclear. We note that the dorsal nerve "hyperplasia" theory in PE patients originated from intraoperative assessments of penile nerve numbers conducted during surgeries where PN was performed alongside penile venous leak surgery and the Nesbit procedure. This theory, proposing that patients with lifelong PE have a higher number of dorsal nerve branches and greater nerve thickness, is gaining traction in contemporary PE literature and shaping current perspectives on PE as a genetically predisposed organic syndrome.[39] However, the urological community should remain aware that this theory originated from ethically questionable intraoperative assessments of penile nerve numbers.[38]

4) 2001–Present (history repeating itself): Global experimentation phase characterized by the integration of intraoperative neurophysiological techniques during PN,[40] the publication of three Chinese PN randomized trials,[39–41] the continued practice of PN under ethically dubious circumstances,[37,42–44] and the widespread, irresponsible promotion of PN (permeated by quackery and deceit, a déjà vu of *Manchete* magazine) on social media and the internet as a safe, simple procedure with negligible or no side effects,[45–51] claims that are both misleading and unfounded. Notably, this phase has also seen the development of PN derivatives, offshoots, or descendants, such as dorsal penile nerve neuromodulation via pulsed radiofrequency,[52] percutaneous computed tomography-guided cryoablation of the dorsal penile nerve,[53] and the implantation of an acellular dermal matrix biomaterial beneath Buck's fascia, referred to by the Chinese authors[54] as "an inner condom technique." Among these, pulsed radiofrequency has been regarded as the more measured and safer approach, with an apparently favorable safety profile, though evidence supporting neuromodulation-based treatment remains weak.[55,56] While it is presented as safer, non-ablative, and ethically developed alternative, it remains a non-ablative offshoot of PN, an evolution tracing back to a procedure rooted in unethical human experimentation. Currently, various sectors of the urological community advocate for additional RCTs (randomized controlled trials) and further studies on PN, radiofrequency neuromodulation, cryoablation, and hyaluronic acid injections, seemingly aiming to establish surgical interventions for PE within American and European urological guidelines. Fig. 2 shows a preliminary diffusion curve illustrating

the spread of PN over time, analogous to the adoption patterns depicted by Barkun et al.[57] for other surgical practices.

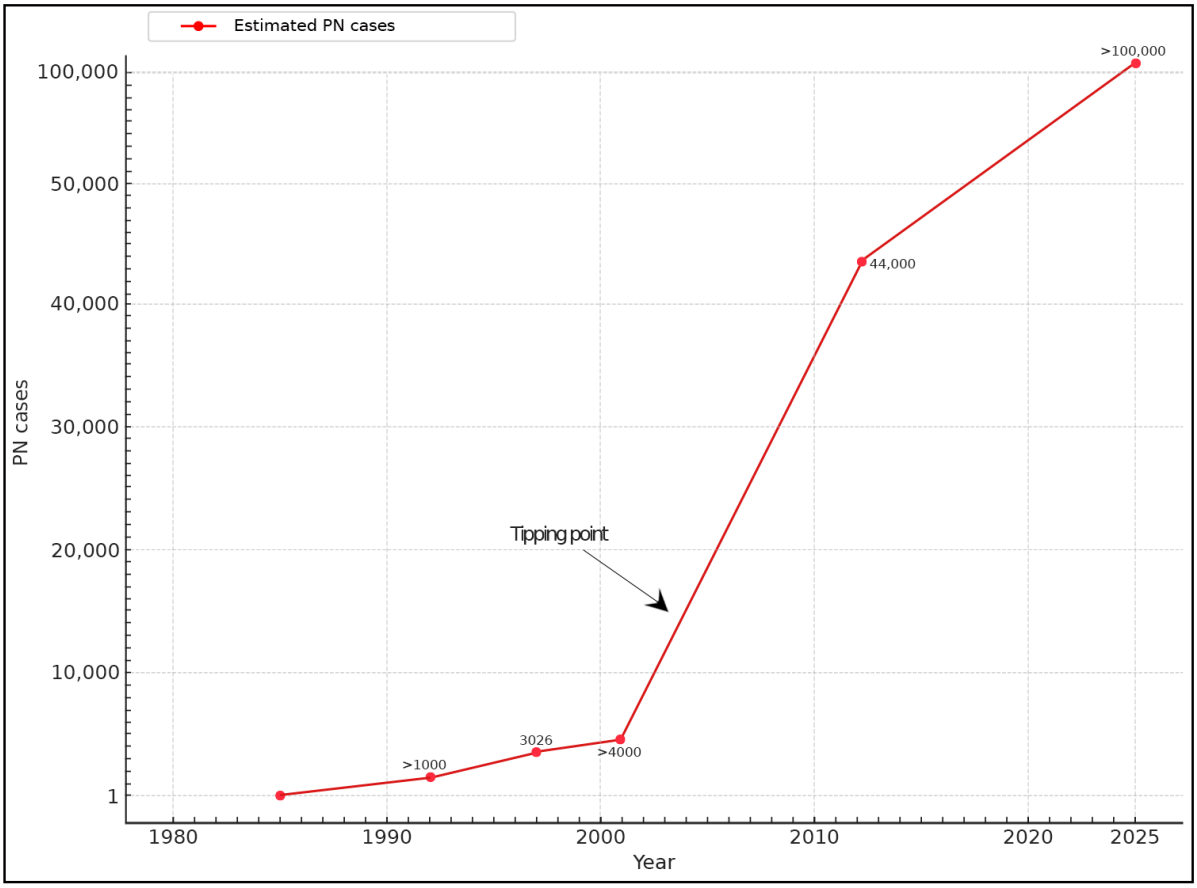

Fig. 2. Diffusion curve for penile neurotomy (PN) over time. The initial point on the curve is set at 1985, an arbitrary estimate due to the lack of reliable data on the exact year of PN's inception in Brazil, although available evidence suggests it began sometime during the 1980s. The case estimates shown are highly conservative, based primarily on figures published by neurotomists themselves.[2,13,58,59] The actual numbers are likely significantly higher, and at any of the five timepoints shown after the initial PN, the true figures may far exceed twice the values presented. The case counts at each of the five timepoints reflect separate, non-cumulative estimates. The estimates are derived from the following sources: by 1992, Romero[2] reported having performed more than 1,000 PNs (without specifying how many beyond that figure); by 1997, Fischer Santos[59] reported a multicentric PN trial with 3,026 cases; by 2001, Dias Bautista et al.[13] reported another multicentric PN trial involving over 4,000 cases (also without indicating how many more); and by 2013, a nationwide survey[58] of South Korean urologists reported 44,000 PNs performed in South Korea alone. This figure was reported without temporal resolution and offered no indication of the period it covers. Thus, the 44,000 cases attributed to 2013 reflect data exclusively from South Korea, and the global number of PN procedures performed by that year was almost certainly far greater. The >100,000 estimate for 2025 is a reasoned extrapolation from the 44,000 cases reported in South Korea alone by 2013, and reflects the continued, undocumented global spread of PN over the subsequent years. The shape of the curve is entirely upward-trending and suggests a potential tipping point around 2001, following the multicentric report by Dias Bautista et al.[13] The curve remains highly preliminary and is intended as an exploratory representation. Robust epidemiological data are needed to accurately map the scale, distribution, and temporal dynamics of the global diffusion of PN. The absence of such data, along with the high PN case counts depicted in the curve for a high-risk experimental practice still discouraged by urological guidelines,[60,61] highlights the broader failure of regulatory oversight within urology and exemplify the well-documented, systemic lack of oversight in surgical development and innovation more broadly.[57,62,63]

A key issue raised by this investigation is that PN has, in some cases, been presumptively carried out as a criminal act on young adult patients (both with and without PE) during circumcision, without their knowledge or informed consent to the neurotomy itself, resulting in devastating psychological sequelae and sexual dysfunction.[42–44,64,iv] These concerns further call into question the procedure's ethical

[iv] McMorrow's 2016 *Vice* article,[42] in particular, exposes a deeply disturbing reality in China, where over a thousand patients (perhaps many more) presumptively underwent PN without proper consent during circumcision and other surgeries. His

legitimacy[4] and underscore the need for inquiry into how it spread with minimal oversight. Of note, psychotic episodes have been reported following PN,[4,58] likely resulting from the profound neural and hedonic impact caused by ablating the innervation of the frenular region, a penile area uniquely specialized for transmitting pleasurable sensations linked to sexual reward and satisfaction.[17–20] Despite the efforts of those known in South American urological circles as the principal international disseminators and surgical enthusiasts of PN, the practice has never been endorsed in American and European urological guidelines, recognized at best as experimental and, at worst, outright discouraged.[60,61,66] Despite these issues, PN continues to be practiced in numerous countries, including South American, European, and Asian countries, where recent publications[39–41] have attempted to legitimize the procedure. The future is caught between the continued legitimization of PN by urologists and journal editors who willfully ignore its sordid past and present, and a reckoning with its ethical and scientific failings.[v]

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investigation raises more questions than it answers: many of the victims came from rural regions across China and were often economically disadvantaged and with limited formal education, a demographic particularly vulnerable to medical exploitation and unethical experimentation. But *why* were these patients specifically targeted for unconsented PNs during circumcision? Was there a larger, more systematic rationale behind their selection? Pressure to incorporate PN as a standard surgical treatment for PE into American and European urological guidelines comes from Asian countries, including China, where it is endorsed in the most recent national guidelines for andrologic diseases.[39,65] At the same time, all three PN randomized trials[39–41] originated from China, including an RCT conducted at a Wuhan center.[39] The alignment of these factors (the widespread unconsented PNs in China, the concentration of PN randomized trials there, and the ongoing push from Chinese urologists advocating for PN's inclusion in urological PE guidelines) raises unsettling questions that merit closer examination. What exactly is happening in China with PN practices? Beyond China, two South Korean studies by Shin et al.[43,44] on medical malpractice lawsuits have also documented several cases of PN procedures performed with violations of informed consent in South Korea, a country where up to 73% of private practice urologists consider PN necessary for treating PE.[4,58] Moon's[65] statement from South Korea that PN should be done "in well selected patients **with consent**" (p. 505) is striking, as it states the obvious, perhaps implicitly conceding that this standard has not always been upheld. What need is there to declare the obvious unless the obvious has been ignored? Confidential data in the presenting author's possession, to be presented in an anonymized manner at the congress, suggests a presumptive case of unconsented PN performed during circumcision in a young patient without PE in a South American country, followed by the forgery of his medical records by the implicated urologist. Taken together with the Brazilian CFMs concerns about consent violations in PN practices since their inception in Brazil,[27] along with documented cases of such violations,[26,37] this body of evidence points to a disturbing international trend. *What exactly has been and continues to be unfolding within the international urological community regarding PN practices?* Against this backdrop, the PN experimentation episode uncovered here draws unsettling parallels to the case of James C. Burt, the American gynecologist notorious for his so-called "Love Surgery," in which he performed unauthorized genital alterations under the guise of therapeutic innovation.[62] Yet, while Burt's misconduct was ultimately exposed and halted as the actions of a lone rogue unethical practitioner, PN has evolved into a widespread, global practice, with its presumed unconsented performance continuing with impunity, the full extent of which remains unknown.

[v] The purported scientific basis of PN remains highly questionable: **(1)** PN risks uncontrolled sensory loss due to the unpredictable dense terminal ventral ramification of severed penile nerves into clusters of corpuscular receptors and nerve bundles[67–70]; **(2)** Anatomical[71,72] and electrophysiological[72,73] evidence shows that lateral branches of the dorsal nerve (typically severed in PN) emit tunical perforators to the corpus spongiosum, risking urethral sensory and autonomic dysfunction alongside the intended dorsal nerve injury. Additionally, delicate branches arising from the inferior surface of the dorsal nerves extend into the cavernosal tunica,[74] potentially functioning as supplementary pro-erectile pathways.[75] These branches are also at risk in PN, further exacerbating neural damage; **(3)** PN entails unresolvable intraoperative uncertainty: no reliable method exists to determine how many nerve branches to cut or spare. Intraoperative penile sensory evoked potentials,[40] proposed to better assess the margin of safety, are inherently limited as they evaluate only a subset of pathways and fiber types. Moreover, they can be normal even in cases of significant sensory deficits due to the complexity and redundancy of nerve pathways. Notably, the Chinese RCT[39] relied on an arbitrary idea of "equilibrium of nerve distribution." The eminent Argentinian urologist, the late Guillermo Gueglio,[66] stated (p. 63): "…surgical neurectomy of dorsal penile nerve filaments has been proposed as a last resort. However, this technique should be strongly discouraged, as it is extremely difficult to determine the exact number of nerve filaments that must be cauterized to achieve the desired outcome. As a result, patients often experience hypoesthesia or anesthesia of the glans after the procedure, sometimes leading to anejaculation and anorgasmia." (translated from Spanish by us). Similarly, a Spanish urologist[76] wrote in 2012, seemingly unaware that PN was undergoing global expansion at the time (p. 686): "Selective neurotomy of multiple fibers of the dorsal penile nerves has been a controversial technique used by a few andrology groups, most of whom have since abandoned it due to its poor outcomes and the irreversible anesthetic effects on the penis" (translated from Spanish by us); **(4)** Extracorporeal penile nerves express varying proportions of molecules associated with autonomic function, such as VIP, NPY, TH, and nNOS,[77,78] the latter being a key transmitter for erection, highlighting PN's potential impact beyond sensory loss; **(5)** PN directly targets the frenular region, the principal erogenous zone of the penis, long recognized not only for its heightened sensitivity but also for its specialized role in sexual pleasure (Fig. 1A).[17–20] Therefore, PN is a procedure fraught with risk and unpredictable outcomes, with potentially detrimental consequences for a young patient's sexual health and overall quality of life.

While it is widely acknowledged that surgical development often proceeds without the scientific and ethical regulatory safeguards applied to pharmaceuticals (aptly summarized by Spodick's phrase,[63] "there is no FDA for the surgeon"), the PN story exemplifies a worst-case scenario: ethically unregulated experimental urological practices carried out on a global scale, with dubious scientific basis and little to no external scrutiny.

Drawing on medicolegal documents,[26,27,37] urological publications, and ethnographic investigation, this presentation explores the role of urologists in promoting PN, and the failure of medical institutions to properly scrutinize its ethics and scientific basis. We will also present original immunohistological data on penile innervation, highlighting the unique and dense innervation that neurotomy targets.[68,67,79] By exposing this ongoing chapter in urological history, we advocate for retrospective accountability, patient safety and informed consent, and call for national/international law enforcement agencies to thoroughly investigate this issue. We also invite the current IJIR editorial board to revisit and reflect on IJIR's historical role in facilitating the dissemination of this ethically and historically fraught practice.

This investigation, to be presented at the World Association for Sexual Health 2025 Congress, provides the first in-depth historical analysis of this issue—a decades-long saga worthy of a Netflix screenplay—tracing its origins, ethical controversies, and ongoing implications, a matter the urological community has long neglected and has yet to confront with the seriousness it demands.

"It is better to curse the darkness than to light the wrong candle."

"Primum non nocere."

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Dispatch from the future: After a few Asian PN RCTs boasting minuscule risks and overwhelmingly high efficacy, PN is now formally included in American and European urological guidelines as a standard surgical intervention for lifelong refractory PE. Its history, one of unbridled quackery, medical misconduct, and human experimentation has been conveniently ignored. We never had any illusions that our exposé would alter its course. The urological community looked the other way then, just as it does now.